



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 15, 2026

Administrator  
The Gardens at Foley LLC  
253 PINE STREET  
FOLEY, MN 56329

RE: CCN:245325

Cycle Start Date: June 25, 2026

Dear Administrator:

On June 25, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
  - How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.



- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## **DEPARTMENT CONTACT**

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Supervisor, Federal Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
1400 E. Lyon St.  
Marshall, MN 56258  
Email: [nikki.harvey@state.mn.us](mailto:nikki.harvey@state.mn.us)  
Office: (320) 223-7318 Mobile: (320) 216-5631

## **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified



as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by September 25, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 25, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

### **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>



A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing  
Compliance Analyst | Federal Enforcement  
Health Regulation Division  
**Minnesota Department of Health**  
[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)  
Office: 651-201-4112





Protecting, Maintaining and Improving the Health of All Minnesotans

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July 15, 2026

Administrator  
The Gardens at Foley LLC

Re: State Nursing Home Licensing Orders

Event ID: 236A44\_H1

Dear Administrator:

The above facility survey was completed on June 25, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html).

The State licensing orders are delineated on the Minnesota Department of Health State



Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

**Supervisor Signature Block here**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

**(Insert signature block here and delete this note)**



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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245325 |                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING                                                                                                                                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>06/25/2026 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>THE GARDENS AT FOLEY LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>253 PINE STREET , FOLEY, Minnesota, 56329                                                                                                                                          |  |                                              |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                        |  | (X5)<br>COMPLETION<br>DATE                   |  |
| F0000                                                        | INITIAL COMMENTS<br><br>On 6/23/26 through 6/25/26, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed.<br><br>H53252865C (3039426) with deficiencies issued at F550, F725.<br><br>H53252952C (3045056)<br><br>H53251777C (3014966, 2999642) with a deficiency issued at F725.<br><br>H53252837C (3037459) with a deficiency issued at F641.<br><br>H53253129C (3040246) with deficiencies issued at F550, F725.<br><br>As a result of the survey an additional deficiency was cited at F684.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. |                                                                     | F0000               |                                                                                                                                                                                                                                 |  | 08/05/2026                                   |  |
| F0725<br>SS = E                                              | Sufficient Nursing Staff<br><br>CFR(s): §483.35(a)(1)(2)<br><br>§483.35 Nursing Services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                     | F0725               | The process of satisfying this requirement has been reviewed and revised as needed to ensure residents who are dependent on staff for activities of daily living (ADLs) are provided with care and services in a timely manner. |  | 08/12/2026                                   |  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

|                                                                       |       |           |
|-----------------------------------------------------------------------|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|-----------------------------------------------------------------------|-------|-----------|



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| NAME OF PROVIDER OR SUPPLIER<br><br>THE GARDENS AT FOLEY LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>253 PINE STREET , FOLEY, Minnesota, 56329 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |                            |
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| F0725<br>SS = E                                              | <p>Continued from page 1</p> <p>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.</p> <p>§483.35(a) Sufficient Staff.</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to ensure they maintained sufficient numbers of staff to assist 5 of 5 residents (R5, R6, R7, R8 and R9) in a timely manner. This had the potential to affect all residents residing on the 300, 400 and 500 units of the facility.</p> <p>Findings include:</p> <p>R5</p> <p>R5's Admission Record indicated she admitted to the facility 3/22/21. R5's diagnoses included chronic kidney disease, obesity and dysphagia.</p> <p>R5's quarterly Minimum Data Set (MDS) dated</p> |                                                                  |  | F0725                                                                                  | <p>Continued from page 1</p> <p>All residents in the facility dependent on staff for Toileting and care tasks have the potential to be affected if this requirement is not met.</p> <p>The electronic medical record (EMAR), to include the plan of care, for R5, R6, R7, R8, and R9, was reviewed and revised as needed to ensure there was no harm or lasting effects.</p> <p>R5, R6, R7, R8, and R9 have been added to call-light committee to review every Friday and for trends to be corrected or staff adjustment.</p> <p>Call Light Committee was formed to review call-light times to ensure timely responsiveness to ensure toileting and care tasks are completed. Committee reviews entire facility call lights-log for that week. Call light times longer than (25) twenty-five minutes are reviewed for trends to add, subtract or move staff around for better response and elimination of long call-light times.</p> <p>The facility completed monthly QAPI and added a PIP for call lights. All staff educated on the facility's expectations for answering call lights to ensure residents who are dependent on staff for toileting and care tasks are provided with toileting and care tasks in a timely manner.</p> <p>The schedule is reviewed daily by Administrator or designee, DON or designee, Scheduler, and Registered Nurse on call manager to ensure staffing levels continue to be in compliance with the federal requirement of sufficient staffing at 42 CFR §483.35(a)(1)-(2) and pursuant to Minnesota Administrative Rules 4658.0510 - Nursing Personnel.</p> <p>Staffing is tracked and audited daily utilizing direct care per patient day ratios (HPPD) via the payroll software, Megadata Healthcare software, Agency staff tracking Excel workbook and is compared against local, state, and federal standards; as found on the CMS Nursing Home Compare website and Monarch Healthcare Management intranet. CMS Payroll Based Journal (PBJ) reports will continue to demonstrate past, present, and future compliance.</p> |                                              | 08/12/2026                 |



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| F0725<br>SS = E                                              | <p>Continued from page 2</p> <p>4/9/26, identified intact cognition and indicated she was dependent on staff to complete toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder and required assistance to transfer.</p> <p>During continuous observation on 6/23/26 at 1:05 p.m. through 2:25 p.m., R5 was seated in her room in a wheelchair in the dark. Nursing assistant (NA)-A approached R5 who told NA-A she needed to be changed. NA-A told R5 she would need to get the lift. NA-A left the room and did not return. At 2:05 p.m., R5 remained seated in her wheelchair with her head down and remained there until 2:25 p.m.</p> <p>During interview on 6/23/26 at 2:26 p.m., nursing assistant (NA)-A stated she should have gone back to assist R5, but she had gotten busy.</p> <p>At 2:33 p.m., staff had still not assisted R5.</p> <p>During interview on 6/23/26 at 3:02 p.m., NA-B stated the day shift had passed on to the evening staff that R5 needed to be changed and said they had not assisted R5 yet.</p> <p>During observation on 6/23/26 at 3:05 p.m., NA-B and NA-C prepared to assist R5 with toileting. R5's room had a strong urine odor. When R5's brief was removed it was saturated with urine and feces. NA-B confirmed R5's pants were soaked with urine.</p> <p>R6</p> <p>R6's Admission record printed 6/30/26, indicated he admitted to the facility 2/26/25.</p> <p>R6's quarterly MDS dated 5/15/26, indicated R6's cognition was intact. R6 was independent with toilet transfers and toilet hygiene but required setup or clean-up assistance for personal hygiene. R6 was occasionally incontinent bowel and bladder.</p> <p>R6's care plan dated 5/21/25, identified an alteration in elimination related to decreased mobility. The care plan directed staff to assist with peri-cares, to provide incontinent products and assist to change as needed (PRN).</p> <p>During observation on 6/24/26 at 8:39a.m., R6 propelled himself from his room and told registered nurse (RN)-A he needed to go to the bathroom. RN-A told R6, "I will find the girls."</p> <p>During interview on 6/24/26 at 3:02 p.m., R6 stated his call light had been on for over an hour that</p> |                                                                  |  | F0725                                                                                  | <p>Continued from page 2</p> <p>Those educated, using Monarch Healthcare Management "Open shift staff policy", included but was not limited to, Administrator, DON, Scheduler and Registered Nurse Care Managers.</p> <p>In an effort to fill all vacancies, the facility will continue with recruitment and retention efforts to hire and retain their own staff.</p> <p>In an effort to fill all vacancies, the facility will continue to contract with External Staffing agencies, as defined by the MN Supplemental Nursing Services Agency (SNSA), and Monarch Healthcare Management float pool for temporary staffing needs.</p> <p>Any deficient practice will be identified and corrected at the time of occurrence.</p> <p>Audits will be completed for R5-R9 call-light times over (25) twenty-five minutes three (3) times per week for four (4) weeks; two (2) times per week for four (4) weeks; One (1) time per week for four (4) weeks and monthly thereafter for one (1) month. Call-light committee will continue to meet every Friday to review that week's call-lights. Audit results will be reviewed at QAPI meetings. Any deficient practice will be identified and corrected at the time of occurrence.</p> <p>Corrective Action will be completed on or before 12 August 2026.</p> |                                              | 08/12/2026                 |



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| NAME OF PROVIDER OR SUPPLIER<br><br>THE GARDENS AT FOLEY LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>253 PINE STREET , FOLEY, Minnesota, 56329 |                                                                                                                          |                                              |                            |
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| F0725<br>SS = E                                              | <p>Continued from page 3</p> <p>morning. R6 said it happened about once per week. R6 stated he had times when he had not made it to the bathroom on time because the call light was not answered and said it bothered him.</p> <p>R7</p> <p>R7’s Admission Record printed 6/30/26, indicated he admitted to the facility 2/13/26.</p> <p>R7’s quarterly MDS dated 5/19/26, indicated R7’s cognition was intact. R7 required partial/moderate assistance from staff for transfers, dressing/undressing, toileting transfers and hygiene. R7 was occasionally incontinent of bladder and frequently incontinent of bowel.</p> <p>R7’s care plan dated 4/27/26, identified and alteration in elimination and alteration in mobility. The care plan directed staff to assist with toileting and assist with movement in and out of bed.</p> <p>R8</p> <p>R8’s Admission Record printed 6/30/26, indicated he admitted to the facility 2/6/24.</p> <p>R8’s significant change MDS dated 5/28/26, indicated R8’s cognition was intact. R8 required partial/moderate assistance for dressing/undressing and was independent with transfers and ambulation.</p> <p>R8’s care plan dated 10/15/24, identified a self-care deficit and directed staff to assist with grooming, bathing and personal hygiene.</p> <p>During interview on 6/24/26 at 3:11 p.m., R8 said “we can’t get any help.” R8 said today was so long he turned on his light because R7’s light was not answered for so long. “He [R7] told me this morning, he waited a long time to get help to get up and get ready for breakfast.”</p> <p>R9</p> <p>R9’s Admission Record indicated she admitted to the facility 6/5/26.</p> <p>R9’s admission MDS dated 6/11/26, indicated R9’s cognition was moderately impaired. R9 required partial/moderate assistance with dressing/undressing, supervision or touching assistance with transfers and toileting hygiene. R9 was frequently incontinent of bowel.</p> |                                                                  |  | F0725                                                                                  |                                                                                                                          |                                              | 08/12/2026                 |



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| F0725<br>SS = E                                              | <p>Continued from page 4</p> <p>R9’s care plan dated 6/5/26, identified an alteration in mobility and directed staff to assist with ambulation, movement in and out of bed and transfers.</p> <p>During interview on 6/24/26 at 3:15 p.m., R9 stated the call light was on a long time and said it was not the staffs’ fault, “they are busy.” R9 said she had a bowel movement and had been waiting to get help to get cleaned up.</p> <p>Call light logs were reviewed for the following rooms for 6/24/26 from 7:00 a.m. – 11:00 a.m.</p> <p>Room 410B (R6), call light was cleared at 8:56 a.m. The call light had been on for 48 minutes and 17 seconds</p> <p>Room 409B (R7), call light was cleared at 9:19 a.m. The call light had been on for 76 minutes and 30 seconds.</p> <p>Room 409A (R8), call light was cleared at 8:37 a.m. The call light had been on for 55 minutes and 43 seconds.</p> <p>Room 402B(R9), call light was cleared at 7:28 a.m. The call light had been on for 57 minutes and 37 seconds.</p> <p>Resident Council Meeting Minutes reviewed for 1/2026 through 6/2026 revealed the following:</p> <p>1/13/26, long call light wait times. One resident indicated they waited so long they had sores on their bottom. A Resident Council Response Form dated 1/22/26, reviewed call light logs for trends and patterns, education completed related to ensuring timely responses to the best of ability for shifts with trends noted.</p> <p>2/17/26, ongoing concerns about long call light wait times. Resident Council Response Form dated 3/15/26, indicated several new staff, management team was working with current and new team members to promote teamwork and division of tasks for efficiency.</p> <p>3/10/26, long call light times while on toilet, not getting washed up on evening shift. Resident Council Response Form dated 3/11/26, indicated residents complained of not getting washed up in the a.m. or p.m., several stated on p.m. they almost never got washed up. Reported by five residents. Resident Council Response Form dated 3/12/26, indicated care management to address residents not</p> |                                                                     |  | F0725                                                                                  |                                                                                                                          |                                              | 08/12/2026                 |



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| F0725<br>SS = E                                              | <p>Continued from page 5<br/>getting washed up at huddle. A second Resident Council Response Form dated 3/12/26, indicated residents being left on toilet, long call light wait times leading to sore bottoms and self-transferring of residents. The response indicated all staff education completed related to teamwork and collaboration to ensure task completion implemented at huddle. A third Resident Council Response Form dated 3/12/26, indicated residents stated they had not been getting showers. One family member had to call so the residents could get a shower, had been two weeks. Resident had been told staff did not have time. The form indicated, would review at huddle, care managers had been implementing a check in process with the NA's and if showers had been completed.</p> <p>4/14/26, 300, 400 and 500 units not receiving a.m. or p.m. cares, not getting washed up. Residents wanted to see management on the floor. Resident Council Response Form dated 4/20/26, indicated residents on the 300, 400 and 500 units stated they could not remember the last time they had been washed up in the a.m. or p.m. shifts. The form indicated staff received education on proper hygiene for all residents and explained residents right to be properly cleaned before bed and when they got up. A second Resident Council Response Form dated 4/20/26, indicated residents would like to see management on the floor and wanted to know why they did not help out. The form indicated upper management to round prior to morning meeting and throughout the day to ensure residents could put a name and face with the management team. A third Resident Council Response Form dated 4/20/26, indicated residents wanted to know who filled in when staff were on break or if they were just left short staffed on the floor. This was causing long wait time for the bathroom. The form indicated residents were informed that floor staff were to inform each other when they went on break and to cover for each other. Staff were to ask management for assistance when they needed help. Another Resident Council Response Form dated 4/20/26, indicated residents wanted proof of follow through and felt they were being “pushed off.” Response indicated the administrator spoke with residents during several activities and explained they were not being pushed off and there were “a lot of moving parts.”</p> <p>5/19/26, residents not getting washed up on day and evening shift on the 500 unit and needing the bathroom while staff is still in the dining room. Resident Council Response Form dated 5/20/26, indicated management and office staff would be on</p> |                                                                     |  | F0725                                                                                  |                                                                                                                          |                                              | 08/12/2026                 |



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| F0725<br>SS = E                                              | <p>Continued from page 6</p> <p>the floor and designated float to tend to residents who were not in the dining room. A second Resident Council Response Form dated 5/20/26, indicated residents stated they are still not getting washed up in the a.m. or p.m. and only one certain NA who worked on the overnight shift would perform a.m. cares. The form indicated care managers had a meeting to ensure they were rounding and laying eyes on the staff to ensure residents were properly cleaned and had clean clothing.</p> <p>6/9/26, cares not getting done, residents sitting on toilet too long. Resident Council Response Forms had not been completed.</p> <p>During interview on 6/24/26 at 4:43 p.m., with the administrator and the director of nursing (DON), the administrator said a little over a month ago they realized they had some grievances related to call lights. The administrator said they formed a team meeting every Friday and went over call lights from the previous week. The DON said they identified a trend in the morning when everyone wanted to get up and were looking at adjusting staff. The DON said mealtimes were the biggest trend so they had looked at increasing management presence to round on the units, answer call lights and if able, complete the task. The administrator said when they pulled the call light logs that morning he was surprised and thought they had been doing pretty good. The administrator said staff was based on per patient days (PPD) but said he did not know the breakdown. The administrator said he felt they had enough staff.</p> <p>During interview on 6/25/26 at 9:16 a.m., NA-E stated the previous day she had been assigned on the 400 unit and worked for about an hour. NA-E said she was told they were overstaffed and she was sent home. NA-E said she was not able to complete all her work before being sent home.</p> <p>During interview on 6/25/26 at 9:41 a.m., NA-F stated she was not all her assigned work during her shift.NA-F said breakfast was 8:00 a.m. and said the NAs were still getting people up and dressed at that time. NA-F said two day shift staff had been sent home early the previous day [6/24/26].</p> <p>During interview on 6/25/26 at 9:11 a.m., licensed practical nurse (LPN)-A stated management told staff they could only have three NA's to cover the 300,400 and 500 units because of census. LPN-A stated she tried the best she could to help out and said it was hard because a lot of residents required assistance from two staff. LPN-A said the long call light wait times was “definitely not uncommon.”</p> |                                                                  |  | F0725                                                                                  |                                                                                                                          |                                              | 08/12/2026                 |



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| F0725<br>SS = E                                              | Continued from page 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                     |  | F0725                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              | 08/12/2026                 |
|                                                              | A policy related to sufficient staff was requested but not received.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                     |  |                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                            |
| F0867<br>SS = E                                              | QAPI/QAA Improvement Activities<br><br>CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br><br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at |                                                                     |  | F0867                                                                                  | The process for satisfying this requirement has been reviewed and revised as needed to ensure compliance with completion of performance improvement projects (PIPs) during QAPI to address problematic areas, create action plans, correct call light waiting times so cares and toileting tasks can be completed in a timely manner.<br><br>All residents that require assistance from staff to complete activities of daily living have the potential to be affected if this regulation is not met.<br><br>All necessary QAPI members have been educated on the QAPI program and call light times PIP plans/goals.<br><br>- Audits will be completed three (3) times per week for four (4) weeks; two (2) times per week for four (4) that require assistance from staff to complete activities of daily living weeks; One (1) time per week for four (4) weeks and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI meetings.<br><br>Any deficient practice will be identified and corrected at the time of occurrence.<br><br>Administrator or Designee is responsible party.<br><br>Corrective Action will be completed on or before August 5, 2026. |                                              | 08/05/2026                 |



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| F0867<br>SS = E                                              | <p>Continued from page 8<br/>performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.</p> <p>§483.75(d)(2) The facility will develop and implement policies addressing:</p> <p>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;</p> <p>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and</p> <p>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.</p> <p>§483.75(e) Program activities.</p> <p>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.</p> <p>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.</p> <p>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.</p> |                                                                     |  | F0867                                                                                  |                                                                                                                          |                                              | 08/05/2026                 |



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| F0867<br>SS = E                                              | <p>Continued from page 9</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facilities Quality Assurance and Performance Improvement (QAPI) committee failed to address resident concerns related to call light wait times which resulted in cares not being performed and toileting tasks not being completed in a timely manner. This had the potential to affect all residents in the facility who required assistance from staff to completed activities of daily living.</p> <p>Findings include:</p> <p>Refer to F725:</p> <p>Based on observation, interview and document review the facility failed to ensure they maintained sufficient numbers of staff to assist residents in a timely manner on the 300, 400 and 500 units of the facility.</p> <p>During document review and interview on 6/25/26 at 1:38 p.m., with the administrator, the 2026, QAPI notes related to staffing were reviewed. The administrator stated in January the notes identified concerns related to staffing as it related to new hires. The administrator said nothing was noted related to call lights for the month of February. In March, the administrator said the committee discussed call light times and training staff to leave lights on until cares were completed. The goal for responding to call lights was nine minutes. In April, long call light times were noted, and the nurse managers were expected to follow-up. The administrator stated in May, long call light times</p> |                                                                     |  | F0867                                                                                  |                                                                                                                          |                                              | 08/05/2026                 |



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| F0867<br>SS = E                                              | <p>Continued from page 10</p> <p>were again identified and said the follow-up was the same as the previous month. The administrator said in June, again long call light wait times were identified and the committee discussed pulling the call light reports each day. The administrator stated he had reviewed the call light reports, and the last few weeks had been really good. Long call light wait times were noted around mealtimes, the plan included to increase management staff on the floor to ensure call lights were being answered and assist with getting residents to and from meals. The administrator stated there had not been discussion related to increasing the amount of staff in the facility related to the concerns.</p> <p>Facility policy Quality Assurance and Performance Improvement dated 2/2025, indicated the facility will develop, implement and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as:</p> <p>Tracking and measure performance; Establishing goals and thresholds for performance measurement; Identifying and prioritizing quality deficiencies; Systematically analyzing underlying causes of systemic quality deficiencies; Developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.</p> |                                                                     |  | F0867                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              | 08/05/2026                 |
| F0550<br>SS = D                                              | <p>Resident Rights/Exercise of Rights</p> <p>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights.</p> <p>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                     |  | F0550                                                                                  | <p>The process for satisfying this requirement has been reviewed and revised as needed to ensure the facility is assisting residents with toileting in a timely manner.</p> <p>R5's toileting assessment has been reassessed with adjustments made to her toileting schedule. Resident wishes to continue to follow the Q2-3hrs during the day, 2300/0300 on NOC toileting schedule and PRN was added. Changes have been made to her care plan, the group sheet, and POC toileting tasks have been adjusted to reflect toileting schedule.</p> <p>R9 has been discharged from the facility.</p> <p>All current residents requiring toileting assistance have the</p> |                                              | 08/14/2026                 |



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| F0550<br>SS = D                                              | <p>Continued from page 11</p> <p>to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights.</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to ensure a dignified toileting experience for 2 of 3 residents (R5, R9) reviewed for incontinence care.</p> <p>Findings include:</p> <p>R5</p> <p>R5's Admission Record indicated she admitted to the facility 3/22/21. R5's diagnoses included chronic kidney disease, obesity and dysphagia.</p> <p>R5's quarterly Minimum Data Set (MDS) dated 4/9/26, identified intact cognition and indicated she was dependent on staff to complete toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder and required assistance to transfer.</p> <p>During continuous observation on 6/23/26 at 1:05 p.m. through 2:25 p.m., R5 was seated in her room in a wheelchair in the dark. Nursing assistant (NA)-A approached R5 who told NA-A she needed to be changed. NA-A told R5 she would need to get the lift. NA-A left the room and did not return. At 2:05 p.m., R5 remained seated in her wheelchair with her</p> |                                                                  |  | F0550                                                                                  | <p>Continued from page 11</p> <p>ability to be affected if this requirement is not met.</p> <p>Appropriate Gardens at Foley staff have been reeducated on this requirement by utilizing Monarch Healthcare Management's "Resident Rights" policy. Nursing staff have been educated on providing toileting and incontinence care per resident preference.</p> <p>DON or designee will audit call light times for residents requiring toileting assistance and incontinence care in a timely manner. Audits will be completed two (2) times per week for two (2) weeks; one (1) time per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.</p> <p>Director of nursing or designee is the responsible party.</p> <p>Corrective action will be complete by August 14th , 2026</p> |                                              | 08/14/2026                 |



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| F0550<br>SS = D                                              | <p>Continued from page 12<br/>head down and remained there until 2:25 p.m.</p> <p>During interview on 6/23/26 at 2:26 p.m., nursing assistant (NA)-A stated she should have gone back to assist R5, but she had gotten busy.</p> <p>At 2:33 p.m., staff had still not assisted R5.</p> <p>During interview on 6/23/26 at 3:02 p.m., NA-B stated the day shift had passed on to the evening staff that R5 needed to be changed and said they had not assisted R5 yet.</p> <p>During observation on 6/23/26 at 3:05 p.m., NA-B and NA-C prepared to assist R5 with toileting. R5's room had a strong urine odor. When R5's brief was removed it was saturated with urine and feces. NA-B confirmed R5's pants were soaked with urine.</p> <p>R5's care plan dated 6/24/26, identified an alteration in elimination and directed staff to use a full body lift for transfers. The care plan indicated R5 required assistance with pericare, bed mobility and assistance with movement in and out of bed.</p> <p>During interview on 6/23/26 at 4:10 p.m., registered nurse (RN)-A stated R5's toileting schedule was changed recently following a knee injury. RN-A said when a resident asked to be changed, staff should assist the resident as soon as they could get to them, depending on call lights. RN-A said waiting over two hours was unacceptable. RN-A further acknowledged she had noticed the urine odor in R5's room.</p> <p>During interview on 6/23/26 at 4:17 p.m., the director of nursing (DON) stated she expected staff to assist a resident "as soon as possible" if the resident asked to be changed. When asked about a reasonable time frame, the DON repeated "as soon as possible." The DON said she definitely would have expected the resident to be assisted in less than an hour and a half and said if staff needed assistance they should have asked the management team for help.</p> <p>R9</p> <p>R9's Admission Record indicated she admitted to the facility on 6/5/26. R9's diagnosis included malnutrition, bladder dysfunction, urine retention and mild dementia.</p> <p>R9's admission MDS dated 6/11/26, identified intact cognition and indicated she required supervision/touching assistance for toileting. The</p> |                                                                     |  | F0550                                                                                  |                                                                                                                          |                                              | 08/14/2026                 |



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| F0550<br>SS = D                                              | <p>Continued from page 13</p> <p>MDS indicated R9 was frequently incontinent of bowel.</p> <p>R9's care plan dated 6/5/26, identified an alteration in mobility and directed staff to assist with ambulation, movement in and out of bed and transfers.</p> <p>A Grievance Form-Nurse/NA Behavior dated 6/22/26, indicated R9 reported on 6/22/26 at 7:00 a.m., NA-D had ripped off her brief very violently, threw it in the garbage and said, "you can do this on your own." R9 did not want NA-D back in her room. A correlating Resolution Report dated 6/22/26, indicated the DON spoke with R9 who denied care concerns that morning.</p> <p>During interview on 6/24/26 at 3:15 p.m., R9 stated she had learned how to take care of herself except when she needed help with her catheter bag. R9 said a lady (NA-D) had been banned from her room and said a few days prior, she had been trying to get her pants down and had pushed her button. R9 said "I don't know what set her off, she ripped my brief off. I thought she [NA-D] was going to slam me into a wall." R9 said she was scared "like this" and demonstrated by shaking her hands. R9 said she filed a complaint but wasn't sure if it went anywhere.</p> <p>A Grievance Form- Care Concern dated 5/20/26, indicated an unidentified resident reported on 5/20/26 at 2:00 a.m., she pushed her call light to be taken to the bathroom and stated the NA (NA-D) said she was unable to take her to the bathroom because she was the only NA on the floor. NA-D told the resident she could put on a brief and go to the bathroom in it. The resident went the whole shift without using the toilet. A correlating Resolution Report dated 5/22/26, indicated the DON interviewed NA-D who said there had been a miscommunication and said she had been trying to offer the resident other options.</p> <p>Resident Council Meeting Minutes for May 2026, indicated NA-D- "very rude."</p> <p>During interview on 6/24/26 at 4:43 p.m., with the administrator and the DON, the administrator stated he needed to look more into how the facility addressed concerns related to NA-D and would get back to this surveyor. No follow up was received.</p> <p>Facility policy was requested but not received.</p> |                                                                  |  | F0550                                                                                  |                                                                                                                          |                                              | 08/14/2026                 |



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| F0641<br>SS = D                                              | <p>Accuracy of Assessments</p> <p>CFR(s): 483.20(g)(h)(i)(j)</p> <p>§483.20(g) Accuracy of Assessments.</p> <p>The assessment must accurately reflect the resident's status.</p> <p>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>§483.20(i) Certification.</p> <p>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.</p> <p>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>§483.20(j) Penalty for Falsification.</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to accurately code a facility acquired pressure ulcer on the Minimum Data Set (MDS) for 1 of 3 residents (R4) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R4's Transfer/Discharge Report printed 6/30/26, indicated she admitted to the facility 3/19/26. R4's diagnoses included vascular dementia, malnutrition and hemiplegia (paralysis or severe weakness affecting one side of the body) and hemiparesis</p> |                                                                     |  | F0641                                                                                  | <p>The process of satisfying this requirement has been reviewed and revised as needed to ensure the facility has accurately coded for a facility acquire d pressure ulceration on the Minimum Data Set (MDS).</p> <p>R4's MDS has been modified to include her pressure ulceration.</p> <p>All current residents with pressure ulcers have the ability to be affected if this requirement is not met.</p> <p>Like residents will be reviewed to ensure accurate MDS coding of assessments, modifications to their MDS will be completed if necessary.</p> <p>Appropriate Gardens at Foley staff have been re-educated on this requirement by utilizing Resident Assessment Instrument (RAI) Manual.</p> <p>DON or designee will conduct audits of the MDS for residents with in-house acquired pressure ulcers to ensure they are accurately coded. Audits will be completed two (2) times per week for two (2) weeks; one (1) time per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.</p> <p>Director of nursing is the responsible party.</p> <p>Corrective action will be complete by August 12th, 2026</p> |                                              | 08/12/2026                 |



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| F0641<br>SS = D                                              | <p>Continued from page 15<br/>(one-sided muscle weakness).</p> <p>R4's Wound Evaluation dated 5/28/26, identified a peri-anal posterior pressure ulcer, stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling).</p> <p>R4's care plan revised 6/21/26, indicated alteration in skin integrity related to overall decline in condition, current wound to coccyx. The care plan directed staff to document on skin condition and keep provider informed.</p> <p>R4's discharge MDS dated 6/7/26, indicated she did not have a pressure ulcer.</p> <p>Facility policy related to MDS coding was requested but none received. The administrator wrote in an e-mail on 6/30/26, the facility followed the Resident Assessment Instrument manual.</p>                                                                                                                                                                                                |                                                                  |  | F0641                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              | 08/12/2026                 |
| F0684<br>SS = D                                              | <p>Quality of Care</p> <p>CFR(s): 483.25</p> <p>§ 483.25 Quality of care</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to investigate the cause of an injury that resulted in pain and a change in transfer status for 1 of 1 resident (R5) reviewed with an injury which occurred during a transfer.</p> <p>Findings include:</p> <p>R5's Admission Record indicated she admitted to the facility 3/22/21. R5's diagnosis included chronic kidney disease, obesity and dysphagia.</p> <p>R5's quarterly Minimum Data Set (MDS) dated 4/9/26, identified intact cognition and indicated she was dependent on staff to complete toileting. The</p> |                                                                  |  | F0684                                                                                  | <p>The process of satisfying this requirement has been reviewed and revised as needed to ensure the facility has investigated the cause of an injury which occurred during a transfer.</p> <p>R5's x-ray results indicated degenerative joint disease, no acute fracture or injury noted.</p> <p>Residents that require assistance with transfers have the potential to be affected if this requirement is not met.</p> <p>Injury was isolated with no other residents being identified as a concern.</p> <p>Appropriate Gardens at Foley staff have been re-educated on this requirement by utilizing Monarch Healthcare management's Abuse Prohibition/Vulnerable Adult Policy</p> <p>Audits will be completed two (2) times per week for two (2) weeks; one (1) time per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.</p> |                                              | 08/05/2026                 |



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| F0684<br>SS = D                                              | <p>Continued from page 16</p> <p>MDS indicated R5 was frequently incontinent of bowel and bladder and required partial to moderate assistance to transfer.</p> <p>R5's care plan dated 10/1/24, identified a self-care deficit and an alteration in elimination and indicated she required assistance from one staff for bed mobility and toileting. The care plan was revised 6/24/26, and directed staff to transfer using a full body mechanical lift and two staff.</p> <p>R5's Progress Notes identified the following:</p> <p>6/16/26, R5 reported the p.m. staff had been very rude and said while transferring, the staff did not listen to her. R5 reported the staff moved too quickly resulting in pain to R5's left knee.</p> <p>6/16/26, Nurse practitioner visited for acute onset of left knee pain. Chart review indicated the pain started following a transfer the previous night. R5 was unable to specify exact mechanism of injury but stated "the aide was not gentle." The pain involved the entire left leg but was most severe in the knee and slightly below. The left knee was swollen and painful with movement. R5 expressed concern regarding the aide who assisted her during the incident.</p> <p>6/19/26, Nurse practitioner (NP) visit note, indicated R5 endorsed that three days prior a staff member attempted to get her out of bed and ended up twisting her knee. Since then had been progressively worse. Staff reported R5 had been refusing to get out of bed due to pain. R5 reported staff had been attempting to help her out of bed and she twisted her knee. The pain had been getting progressively worse and she was unable to get out of bed due to the pain. Orders included limit weight bearing for two weeks and a knee immobilizer or brace. Findings suggested a ligament injury.</p> <p>During observation on 6/23/26 at 3:05 p.m., nursing assistant (NA)-B and NA-C prepared to transfer R4 using a mechanical lift. NA-B stated something happened when R5 had been transferred before she needed the lift and her knee twisted. R4 was saying "ouch" when staff touched her knee. During the transfer, R4 said, "ouch, please." When staff rolled R4 in the bed, R4 said "oh, it hurts so" and continued vocalize pain throughout being rolled and changed in the bed.</p> <p>During interview on 6/23/26 at 4:10 p.m., registered nurse (RN)-A stated the previous week, R5 was being transferred and she "kind of tweaked her</p> |                                                                  |  | F0684                                                                                  | <p>Continued from page 16</p> <p>Director of Nursing or Designee is the responsible party.</p> <p>Corrective action will be complete by August 5th, 2026</p> |                                              | 08/05/2026                 |



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| F0684<br>SS = D                                              | <p>Continued from page 17</p> <p>knee.” RN-A said the next morning R5 complained of knee pain and did not want to get out of bed. RN-A said R5 told her the transfer the evening before, "Had not gone well."</p> <p>During interview on 6/23/26 at 4:17 p.m., the director of nursing (DON) stated R5 had reported knee pain and said they investigated the source of the pain. The DON said staff had gone in to transfer R5 and she had struggled to stand so the staff got help from another staff person and eventually used a mechanical lift. The DON said she interviewed R5 about the staff being rude during the transfer and said R5 liked things done a certain way and felt it was rude that staff had not followed her routine. The DON provided statements from a nursing assistant who had not cared for R5 that night and said R5 had first reported the concern to a nurse but she did not have a statement from that nurse. The DON said the other statements were in e-mails and she would look for them.</p> <p>During interview on 6/24/26 at approximately 8:00 a.m., the DON provided copies of handwritten papers, in her own handwriting, and said they were the statements from the other parties involved. The DON said because there was information in the e-mails that pertained to other things not involved in the investigation, she could not provide them.</p> <p>During interview on 6/24/26 at 12:10 p.m., with the administrator and DON, the administrator stated he would have to talk to corporate leadership about the e-mails and said it was not their policy to give out internal communication. The administrator returned a few minutes later and said there was nothing in the e-mails and said the DON had found the papers in a different file. The DON was asked why she told the surveyor the interviews were in an e-mail and the DON stated, “I don’t know why I told you that.”</p> <p>During interview on 6/25/26 at 10:28 a.m., R5 stated since her knee injury, when the staff rolled her it hurt and said she couldn’t get into the bathroom. When asked how her knee was injured, R5 stated the NA, “Did not want to be told nothing, so the whole routine was wrong.” R5 said the NA couldn’t get her in bed and R5 told her she needed to get some help but the NA did not listen. R5 said NA eventually did get help. One NA was in front of her and the other NA was behind her and they were squeezing her around the arms. R5 said, “she [NA] was very rude,” and said, “that’s when the bad thing came.” R5 said her knee had not hurt prior to that incident. R5 said, "I didn’t want to write her up," and said she was told they got rid of the NA. R5 said, “I don’t want to</p> |                                                                     |  | F0684                                                                                  |                                                                                                                          |                                              | 08/05/2026                 |



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| F0684<br>SS = D                                              | Continued from page 18<br>have her again."<br><br>Facility policy Abuse Prohibition/Vulnerable Adult<br>Policy indicated the facility investigation team will<br>review all incident reports including those that<br>indicate and injury of unknown origin and determine<br>if further investigation is needed. The facility will<br>provide proper follow up communication related to<br>the incident across all shifts. |                                                                     |  | F0684                                                                                  |                                                                                                                          |                                              | 08/05/2026                 |



Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                                 |  | (X3) DATE SURVEY COMPLETED<br><br>06/25/2026 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>THE GARDENS AT FOLEY LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                    |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>253 PINE STREET , FOLEY, Minnesota, 56329                                   |  |                                              |  |
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| 20000                                                        | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 6/23/26 through 6/25/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaints were reviewed during the survey.</p> |                                                    | 20000               |                                                                                                                          |  | 08/05/2026                                   |  |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| 20000                                                        | Continued from page 1<br><br>H53252865C (3039426) with licensing orders issued at 0800,1805.<br><br>H53252952C (3045056)<br><br>H53251777C (3014966, 2999642) with a licensing order issued at 0800.<br><br>H53252837C (3037459)<br><br>H53253129C (3040246) with licensing orders issued at 0800,1805.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                    | 20000               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 08/05/2026                                   |  |
| 20800                                                        | Nursing Personnel; Staffing requirements<br><br>CFR(s): MN Rule 4658.0510 Subp. 1<br><br>Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review the facility failed to ensure they maintained sufficient numbers of staff to assist 5 of 5 residents (R5, R6, R7, R8 and R9) in a timely manner. This had the potential to affect all residents residing on the 300, 400 and 500 units of the facility.<br><br>Findings include:<br><br>R5<br><br>R5's Admission Record indicated she admitted to the facility 3/22/21. R5's diagnoses included chronic kidney disease, obesity and dysphagia.<br><br>R5's quarterly Minimum Data Set (MDS) dated 4/9/26, identified intact cognition and indicated she was dependent on staff to complete toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder and required assistance to transfer.<br><br>During continuous observation on 6/23/26 at 1:05 p.m. through 2:25 p.m., R5 was seated in her room in a wheelchair in the dark. Nursing assistant (NA)-A approached R5 who told NA-A she needed to be |                                                    | 20800               | The process of satisfying this requirement has been reviewed and revised as needed to ensure residents who are dependent on staff for activities of daily living (ADLs) are provided with care and services in a timely manner.<br><br>All residents in the facility dependent on staff for Toileting and care tasks have the potential to be affected if this requirement is not met.<br><br>The electronic medical record (EMAR), to include the plan of care, for R5, R6, R7, R8, and R9, was reviewed and revised as needed to ensure there was no harm or lasting effects.<br><br>R5, R6, R7, R8, and R9 have been added to call-light committee to review every Friday and for trends to be corrected or staff adjustment.<br><br>Call Light Committee was formed to review call-light times to ensure timely responsiveness to ensure toileting and care tasks are completed. Committee reviews entire facility call lights-log for that week. Call light times longer than (25) twenty-five minutes are reviewed for trends to add, subtract or move staff around for better response and elimination of long call-light times.<br><br>The facility completed monthly QAPI and added a PIP for call lights. All staff educated on the facility's expectations for answering call lights to ensure residents who are dependent on staff for toileting and care tasks are provided with toileting and care tasks in a timely manner.<br><br>The schedule is reviewed daily by Administrator or |  | 08/12/2026                                   |  |



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| 20800                                                        | <p>Continued from page 2</p> <p>changed. NA-A told R5 she would need to get the lift. NA-A left the room and did not return. At 2:05 p.m., R5 remained seated in her wheelchair with her head down and remained there until 2:25 p.m.</p> <p>During interview on 6/23/26 at 2:26 p.m., nursing assistant (NA)-A stated she should have gone back to assist R5, but she had gotten busy.</p> <p>At 2:33 p.m., staff had still not assisted R5.</p> <p>During interview on 6/23/26 at 3:02 p.m., NA-B stated the day shift had passed on to the evening staff that R5 needed to be changed and said they had not assisted R5 yet.</p> <p>During observation on 6/23/26 at 3:05 p.m., NA-B and NA-C prepared to assist R5 with toileting. R5’s room had a strong urine odor. When R5’s brief was removed it was saturated with urine and feces. NA-B confirmed R5's pants were soaked with urine.</p> <p>R6</p> <p>R6’s Admission record printed 6/30/26, indicated he admitted to the facility 2/26/25.</p> <p>R6’s quarterly MDS dated 5/15/26, indicated R6’s cognition was intact. R6 was independent with toilet transfers and toilet hygiene but required setup or clean-up assistance for personal hygiene. R6 was occasionally incontinent bowel and bladder.</p> <p>R6’s care plan dated 5/21/25, identified an alteration in elimination related to decreased mobility. The care plan directed staff to assist with peri-cares, to provide incontinent products and assist to change as needed (PRN).</p> <p>During observation on 6/24/26 at 8:39a.m., R6 propelled himself from his room and told registered nurse (RN)-A he needed to go to the bathroom. RN-A told R6, “I will find the girls.”</p> <p>During interview on 6/24/26 at 3:02 p.m., R6 stated his call light had been on for over an hour that morning. R6 said it happened about once per week. R6 stated he had times when he had not made it to the bathroom on time because the call light was not answered and said it bothered him.</p> <p>R7</p> <p>R7’s Admission Record printed 6/30/26, indicated he admitted to the facility 2/13/26.</p> |                                                    |  | 20800                                                                                  | <p>Continued from page 2</p> <p>designee, DON or designee, Scheduler, and Registered Nurse on call manager to ensure staffing levels continue to be in compliance with the federal requirement of sufficient staffing at 42 CFR §483.35(a)(1)-(2) and pursuant to Minnesota Administrative Rules 4658.0510 - Nursing Personnel.</p> <p>Staffing is tracked and audited daily utilizing direct care per patient day ratios (HPPD) via the payroll software, Megadata Healthcare software, Agency staff tracking Excel workbook and is compared against local, state, and federal standards; as found on the CMS Nursing Home Compare website and Monarch Healthcare Management intranet. CMS Payroll Based Journal (PBJ) reports will continue to demonstrate past, present, and future compliance.</p> <p>Those educated, using Monarch Healthcare Management “Open shift staff policy”, included but was not limited to, Administrator, DON, Scheduler and Registered Nurse Care Managers.</p> <p>In an effort to fill all vacancies, the facility will continue with recruitment and retention efforts to hire and retain their own staff.</p> <p>In an effort to fill all vacancies, the facility will continue to contract with External Staffing agencies, as defined by the MN Supplemental Nursing Services Agency (SNSA), and Monarch Healthcare Management float pool for temporary staffing needs.</p> <p>Any deficient practice will be identified and corrected at the time of occurrence.</p> <p>Audits will be completed for R5-R9 call-light times over (25) twenty-five minutes three (3) times per week for four (4) weeks; two (2) times per week for four (4) weeks; One (1) time per week for four (4) weeks and monthly thereafter for one (1) month. Call-light committee will continue to meet every Friday to review that week’s call-lights. Audit results will be reviewed at QAPI meetings. Any deficient practice will be identified and corrected at the time of occurrence.</p> <p>Corrective Action will be completed on or before 12 August 2026.</p> |                                              | 08/12/2026                 |



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| 20800                                                        | <p>Continued from page 3</p> <p>R7’s quarterly MDS dated 5/19/26, indicated R7’s cognition was intact. R7 required partial/moderate assistance from staff for transfers, dressing/undressing, toileting transfers and hygiene. R7 was occasionally incontinent of bladder and frequently incontinent of bowel.</p> <p>R7’s care plan dated 4/27/26, identified and alteration in elimination and alteration in mobility. The care plan directed staff to assist with toileting and assist with movement in and out of bed.</p> <p>R8</p> <p>R8’s Admission Record printed 6/30/26, indicated he admitted to the facility 2/6/24.</p> <p>R8’s significant change MDS dated 5/28/26, indicated R8’s cognition was intact. R8 required partial/moderate assistance for dressing/undressing and was independent with transfers and ambulation.</p> <p>R8’s care plan dated 10/15/24, identified a self-care deficit and directed staff to assist with grooming, bathing and personal hygiene.</p> <p>During interview on 6/24/26 at 3:11 p.m., R8 said “we can’t get any help.” R8 said today was so long he turned on his light because R7’s light was not answered for so long. “He [R7] told me this morning, he waited a long time to get help to get up and get ready for breakfast.”</p> <p>R9</p> <p>R9’s Admission Record indicated she admitted to the facility 6/5/26.</p> <p>R9’s admission MDS dated 6/11/26, indicated R9’s cognition was moderately impaired. R9 required partial/moderate assistance with dressing/undressing, supervision or touching assistance with transfers and toileting hygiene. R9 was frequently incontinent of bowel.</p> <p>R9’s care plan dated 6/5/26, identified an alteration in mobility and directed staff to assist with ambulation, movement in and out of bed and transfers.</p> <p>During interview on 6/24/26 at 3:15 p.m., R9 stated the call light was on a long time and said it was not the staffs’ fault, “they are busy.” R9 said she had a bowel movement and had been waiting to get help to get cleaned up.</p> |                                                    |  | 20800                                                                                  |                                                                                                                          |                                              | 08/12/2026                 |



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| 20800                                                        | <p>Continued from page 4</p> <p>Call light logs were reviewed for the following rooms for 6/24/26 from 7:00 a.m. – 11:00 a.m.</p> <p>Room 410B (R6), call light was cleared at 8:56 a.m. The call light had been on for 48 minutes and 17 seconds</p> <p>Room 409B (R7), call light was cleared at 9:19 a.m. The call light had been on for 76 minutes and 30 seconds.</p> <p>Room 409A (R8), call light was cleared at 8:37 a.m. The call light had been on for 55 minutes and 43 seconds.</p> <p>Room 402B(R9), call light was cleared at 7:28 a.m. The call light had been on for 57 minutes and 37 seconds.</p> <p>Resident Council Meeting Minutes reviewed for 1/2026 through 6/2026 revealed the following:</p> <p>1/13/26, long call light wait times. One resident indicated they waited so long they had sores on their bottom. A Resident Council Response Form dated 1/22/26, reviewed call light logs for trends and patterns, education completed related to ensuring timely responses to the best of ability for shifts with trends noted.</p> <p>2/17/26, ongoing concerns about long call light wait times. Resident Council Response Form dated 3/15/26, indicated several new staff, management team was working with current and new team members to promote teamwork and division of tasks for efficiency.</p> <p>3/10/26, long call light times while on toilet, not getting washed up on evening shift. Resident Council Response Form dated 3/11/26, indicated residents complained of not getting washed up in the a.m. or p.m., several stated on p.m. they almost never got washed up. Reported by five residents. Resident Council Response Form dated 3/12/26, indicated care management to address residents not getting washed up at huddle. A second Resident Council Response Form dated 3/12/26, indicated residents being left on toilet, long call light wait times leading to sore bottoms and self-transferring of residents. The response indicated all staff education completed related to teamwork and collaboration to ensure task completion implemented at huddle. A third Resident Council Response Form dated 3/12/26, indicated residents stated they had not been getting showers. One family member had</p> |                                                    |  | 20800                                                                                  |                                                                                                                          |                                              | 08/12/2026                 |



Minnesota Department of Health

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| 20800                                                        | <p>Continued from page 5</p> <p>to call so the residents could get a shower, had been two weeks. Resident had been told staff did not have time. The form indicated, would review at huddle, care managers had been implementing a check in process with the NA's and if showers had been completed.</p> <p>4/14/26, 300, 400 and 500 units not receiving a.m. or p.m. cares, not getting washed up. Residents wanted to see management on the floor. Resident Council Response Form dated 4/20/26, indicated residents on the 300, 400 and 500 units stated they could not remember the last time they had been washed up in the a.m. or p.m. shifts. The form indicated staff received education on proper hygiene for all residents and explained residents right to be properly cleaned before bed and when they got up. A second Resident Council Response Form dated 4/20/26, indicated residents would like to see management on the floor and wanted to know why they did not help out. The form indicated upper management to round prior to morning meeting and throughout the day to ensure residents could put a name and face with the management team. A third Resident Council Response Form dated 4/20/26, indicated residents wanted to know who filled in when staff were on break or if they were just left short staffed on the floor. This was causing long wait time for the bathroom. The form indicated residents were informed that floor staff were to inform each other when they went on break and to cover for each other. Staff were to ask management for assistance when they needed help. Another Resident Council Response Form dated 4/20/26, indicated residents wanted proof of follow through and felt they were being "pushed off." Response indicated the administrator spoke with residents during several activities and explained they were not being pushed off and there were "a lot of moving parts."</p> <p>5/19/26, residents not getting washed up on day and evening shift on the 500 unit and needing the bathroom while staff is still in the dining room. Resident Council Response Form dated 5/20/26, indicated management and office staff would be on the floor and designated float to tend to residents who were not in the dining room. A second Resident Council Response Form dated 5/20/26, indicated residents stated they are still not getting washed up in the a.m. or p.m. and only one certain NA who worked on the overnight shift would perform a.m. cares. The form indicated care managers had a meeting to ensure they were rounding and laying eyes on the staff to ensure residents were properly cleaned and had clean clothing.</p> |                                                    |  | 20800                                                                                  |                                                                                                                          |                                              | 08/12/2026                 |



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| 20800                                                        | <p>Continued from page 6</p> <p>6/9/26, cares not getting done, residents sitting on toilet too long. Resident Council Response Forms had not been completed.</p> <p>During interview on 6/24/26 at 4:43 p.m., with the administrator and the director of nursing (DON), the administrator said a little over a month ago they realized they had some grievances related to call lights. The administrator said they formed a team meeting every Friday and went over call lights from the previous week. The DON said they identified a trend in the morning when everyone wanted to get up and were looking at adjusting staff. The DON said mealtimes were the biggest trend so they had looked at increasing management presence to round on the units, answer call lights and if able, complete the task. The administrator said when they pulled the call light logs that morning he was surprised and thought they had been doing pretty good. The administrator said staff was based on per patient days (PPD) but said he did not know the breakdown. The administrator said he felt they had enough staff.</p> <p>During interview on 6/25/26 at 9:16 a.m., NA-E stated the previous day she had been assigned on the 400 unit and worked for about an hour. NA-E said she was told they were overstaffed and she was sent home. NA-E said she was not able to complete all her work before being sent home.</p> <p>During interview on 6/25/26 at 9:41 a.m., NA-F stated she was not all her assigned work during her shift.NA-F said breakfast was 8:00 a.m. and said the NAs were still getting people up and dressed at that time. NA-F said two day shift staff had been sent home early the previous day [6/24/26].</p> <p>During interview on 6/25/26 at 9:11 a.m., licensed practical nurse (LPN)-A stated management told staff they could only have three NA's to cover the 300,400 and 500 units because of census. LPN-A stated she tried the best she could to help out and said it was hard because a lot of residents required assistance from two staff. LPN-A said the long call light wait times was “definitely not uncommon.”</p> <p>A policy related to sufficient staff was requested but not received.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee, could review resident acuity as it relates to identified staffing concerns. The administrator or designee could conduct random audits of call lights to ensure appropriate care and services are implemented in a timely manner.</p> |                                                    | 20800               |                                                                                                                          |  | 08/12/2026                                   |  |



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| 20800                                                        | Continued from page 7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                    |  | 20800                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                              | 08/12/2026                 |
| 21805                                                        | <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> <p>Patients &amp; Residents of HC Fac.Bill of Rights</p> <p>CFR(s): MN St. Statute 144.651 Subd. 5</p> <p>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to ensure a dignified toileting experience for 2 of 3 residents (R5, R9) reviewed for incontinence care.</p> <p>Findings include:</p> <p>R5</p> <p>R5's Admission Record indicated she admitted to the facility 3/22/21. R5's diagnoses included chronic kidney disease, obesity and dysphagia.</p> <p>R5's quarterly Minimum Data Set (MDS) dated 4/9/26, identified intact cognition and indicated she was dependent on staff to complete toileting. The MDS indicated R5 was frequently incontinent of bowel and bladder and required assistance to transfer.</p> <p>During continuous observation on 6/23/26 at 1:05 p.m. through 2:25 p.m., R5 was seated in her room in a wheelchair in the dark. Nursing assistant (NA)-A approached R5 who told NA-A she needed to be changed. NA-A told R5 she would need to get the lift. NA-A left the room and did not return. At 2:05 p.m., R5 remained seated in her wheelchair with her head down and remained there until 2:25 p.m.</p> <p>During interview on 6/23/26 at 2:26 p.m., nursing assistant (NA)-A stated she should have gone back to assist R5, but she had gotten busy.</p> <p>At 2:33 p.m., staff had still not assisted R5.</p> <p>During interview on 6/23/26 at 3:02 p.m., NA-B stated the day shift had passed on to the evening staff that R5 needed to be changed and said they had not assisted R5 yet.</p> |                                                    |  | 21805                                                                                  | <p>The process for satisfying this requirement has been reviewed and revised as needed to ensure the facility is assisting residents with toileting in a timely manner.</p> <p>R5's toileting assessment has been reassessed with adjustments made to her toileting schedule. Resident wishes to continue to follow the Q2-3hrs during the day, 2300/0300 on NOC toileting schedule and PRN was added. Changes have been made to her care plan, the group sheet, and POC toileting tasks have been adjusted to reflect toileting schedule.</p> <p>R9 has been discharged from the facility.</p> <p>All current residents requiring toileting assistance have the ability to be affected if this requirement is not met.</p> <p>Appropriate Gardens at Foley staff have been reeducated on this requirement by utilizing Monarch Healthcare Management's "Resident Rights" policy. Nursing staff have been educated on providing toileting and incontinence care per resident preference.</p> <p>DON or designee will audit call light times for residents requiring toileting assistance and incontinence care in a timely manner. Audits will be completed two (2) times per week for two (2) weeks; one (1) time per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.</p> <p>Director of nursing or designee is the responsible party.</p> <p>Corrective action will be complete by August 14th , 2026</p> |                                              | 08/14/2026                 |



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| 21805                                                        | <p>Continued from page 8</p> <p>During observation on 6/23/26 at 3:05 p.m., NA-B and NA-C prepared to assist R5 with toileting. R5’s room had a strong urine odor. When R5’s brief was removed it was saturated with urine and feces. NA-B confirmed R5's pants were soaked with urine.</p> <p>R5’s care plan dated 6/24/26, identified an alteration in elimination and directed staff to use a full body lift for transfers. The care plan indicated R5 required assistance with pericare, bed mobility and assistance with movement in and out of bed.</p> <p>During interview on 6/23/26 at 4:10 p.m., registered nurse (RN)-A stated R5’s toileting schedule was changed recently following a knee injury. RN-A said when a resident asked to be changed, staff should assist the resident as soon as they could get to them, depending on call lights. RN-A said waiting over two hours was unacceptable. RN-A further acknowledged she had noticed the urine odor in R5’s room.</p> <p>During interview on 6/23/26 at 4:17 p.m., the director of nursing (DON) stated she expected staff to assist a resident “as soon as possible” if the resident asked to be changed. When asked about a reasonable time frame, the DON repeated “as soon as possible.” The DON said she definitely would have expected the resident to be assisted in less than an hour and a half and said if staff needed assistance they should have asked the management team for help.</p> <p>R9</p> <p>R9’s Admission Record indicated she admitted to the facility on 6/5/26. R9’s diagnosis included malnutrition, bladder dysfunction, urine retention and mild dementia.</p> <p>R9’s admission MDS dated 6/11/26, identified intact cognition and indicated she required supervision/touching assistance for toileting. The MDS indicated R9 was frequently incontinent of bowel.</p> <p>R9’s care plan dated 6/5/26, identified an alteration in mobility and directed staff to assist with ambulation, movement in and out of bed and transfers.</p> <p>A Grievance Form-Nurse/NA Behavior dated 6/22/26, indicated R9 reported on 6/22/26 at 7:00 a.m., NA-D had ripped off her brief very violently, threw it in the garbage and said, “you can do this</p> |                                                    | 21805               |                                                                                                                          |  | 08/14/2026                                   |  |



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| 21805                                                        | <p>Continued from page 9</p> <p>on your own.” R9 did not want NA-D back in her room. A correlating Resolution Report dated 6/22/26, indicated the DON spoke with R9 who denied care concerns that morning.</p> <p>During interview on 6/24/26 at 3:15 p.m., R9 stated she had learned how to take care of herself except when she needed help with her catheter bag. R9 said a lady (NA-D) had been banned from her room and said a few days prior, she had been trying to get her pants down and had pushed her button. R9 said “I don’t know what set her off, she ripped my brief off. I thought she [NA-D] was going to slam me into a wall.” R9 said she was scared “like this” and demonstrated by shaking her hands. R9 said she filed a complaint but wasn’t sure if it went anywhere.</p> <p>A Grievance Form- Care Concern dated 5/20/26, indicated an unidentified resident reported on 5/20/26 at 2:00 a.m., she pushed her call light to be taken to the bathroom and stated the NA (NA-D) said she was unable to take her to the bathroom because she was the only NA on the floor. NA-D told the resident she could put on a brief and go to the bathroom in it. The resident went the whole shift without using the toilet. A correlating Resolution Report dated 5/22/26, indicated the DON interviewed NA-D who said there had been a miscommunication and said she had been trying to offer the resident other options.</p> <p>Resident Council Meeting Minutes for May 2026, indicated NA-D- “very rude.”</p> <p>During interview on 6/24/26 at 4:43 p.m., with the administrator and the DON, the administrator stated he needed to look more into how the facility addressed concerns related to NA-D and would get back to this surveyor. No follow up was received.</p> <p>Facility policy was requested but not received.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee, could educate staff related to resident rights as it relates to dignity. The administrator, director of nursing or designee could conduct random audits and/or resident interviews to ensure resident rights during the delivery of care.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> |                                                    |  | 21805                                                                                  |                                                                                                                          |                                              | 08/14/2026                 |